ISSN 1512-1801

SYMPTOMS SEVERITY, SOCIAL SUPPORT AND QUALITY OF LIFE IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER

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Abstract

Aims. *The present study was conducted to examined association between Symptoms Severity, Social Support and Quality of Life among patients with Major Depressive Disorder.* ***Methods.*** *The current study used correlational research design. One-hundred participants were recruited through non-probability purposive sampling technique. Hamilton Depression Rating Scale (Hamilton, 1960), The Multi-dimensional Scale for Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988) and World Health Organization Quality of Life Scale (WHOQOL Group, 1997) were used as an assessment measures.* ***Results.*** *Results revealed that symptoms severity has significant ($p<.05$) negative relationship with quality of life. Findings also revealed that females with major depressive disorder have higher level of social support as compare to males with major depressive disorder. In addition, regression findings showed symptoms severity was significant predictor of quality of life among patients with major depressive disorder.* ***Conclusions.*** *The current study concluded that lower level of symptoms severity leads towards higher level of quality of life among depressive patients. Based on this study, it is not particular for professionals or students to be attentive from social support toward better quality of life in the Pakistani culture but also to be educated the culture itself and scientific area.*

Keywords*: Symptoms Severity, Social Support, Quality of Life, Major Depressive Disorder*

1. Introduction

Psychological diseases are psychiatric conditions which affect people's routine functioning, capability to sustain societal relations, and lessening their quality of life (QOL). Social support is important because it is crucial for psychological wellbeing likewise increasing quality of life of psychological patients. There is a gap in previous researches such as, at recognizing other important factors, with the eventual aim of developing treatment to help patients in their efforts to sustain their quality life though living with major depressive disorder. The major gaps in previous literature were the use of the correlational design and the purposive sampling technique (Aburuz, 2018). Therefore, the aim of the present research to study the association between symptoms severity, social support and quality of life in clients with major depressive illness. Moreover, results of the present study are helpful for experts to be up-to-date about the psychological distress and expect healthier quality of life from the major depressive disorder patients in Pakistan community.

Depression found to be an important general healthiness issues internationally, particularly in developmental countries. Except the importance of general health issues, the intervention gap for this disease is between 76% to 85% in developmental countries and 35% to 50% in developed countries (WHO, 2013). In DSM-5 criteria, the signs are total to regulate the occurrence or the absenteeism of depressive phase (APA, 2013). Therefore, the DSM supposes that the unhappiness theory might be measured unidimensional. Though, numerous researches have defined diverse subtypes of sadness (Loo, Jonge, Romeijn, Kessler &Schoevers, 2012). Moreover, the two-factor model of sadness has been tested through researches on the feature erection of the DSM indications criteria (Hoen et al., 2010). Elhai et al. (2012) have stated that a unidimensional model fits better comparatively the one-factor unidimensional mode. They revealed depressive signs are best characterized through bodily and non-bodily features. The bodily things comprised sleep disturbances, appetite or weight variations, inattention, exhaustion, and psychomotor distress/delay.

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The non-somatic aspect involved of emotional items for instance miserable mood, lack of motivation, worthlessness and death phobia.

1.1 Symptoms Severity

The occurrence and intensity of signs among aged indoor clients with long-lasting diseases can have a severe bad effect on their quality of life (Cleeland, 2007). The severity of the indications and the period of the psychological disease are revealed to be what places the extreme pressure on families (Rose & Liao, 2005), and a relationship between caretaker drain and negatively influenced the wellbeing has been described (Shah et al., 2010). Furthermore, high stages of psychological suffering have been related with lower feeling of consistency (Suresky et al., 2008). Moreover, to severity of symptoms, Limited researches have also studied the effect of the scientific appearance of indications on quality of life. Lee et al. (2005) stated that emotional depressive signs, like lack of motivation, had an important contrary association with presentation in a model of concentration task. Suicidal conduct has also been revealed to significantly correlated with the impaired explanation of societal incentives, such has extreme contemplation (Raes et al., 2006).

1.2 Social Support

Social support is an interchange of assets between at minimum two persons seeming by the benefactor or the receiver to be intentional to improve the happiness of the receiver (Zimet et al,. 1988). Social support is definite as the presence of some individuals around or easy access to the people on whom on can depend on, who facilitate the depressed individuals (Bodla. Saima & Ammar, 2012). Moreover, social support is an invariable that effects depressive symptomatology. A huge number of researches express that depressed individual have important general psychosocial problems. Specially, advanced stages of depressive signs are related with low levels of social support. Perceived social support mentions to the value of emotional support providing by others. Investigation also proposes that degrees of perceived social support are considerably related with measures of reduced stress and psychological distress, likewise with better measures of happiness (Haslam, Pakenham, & Smith, 2006).

1.3 Quality of Life

Quality of life is reflected like a symbol of overall enjoyment, with joyfulness and happiness with life like a wide-ranging. The highest overall explanation of quality of life, recommended through WHO, was: ‘the individual’s opinion of their worth in life, within the perception of state and cultural approaches in which they live and in relation to their aims, expectations, standards and fears’ (Whoqol, 2016).

However, quality of life means a respectable life. A respectable life is the similar like living a life with a great superiority. This might appear obvious, but it is essential to create such a modest explanation, as therapeutic terminology frequently utilizes very thin ideas of the quality of life (such as, side effect outlines). Quality of life relate on the great and utmost general level of life. All great faiths and beliefs have a concept of a respectable life extending from explain. That a respectable life is achieved by applied rules to appeals to involve in a sure optimistic approach to life or to explore into the complexities of your own being. Views regarding a great life are carefully related to the nation. While individuals in a European nation opinion a moral life, the ethnic training makes them incline to comprise pleasure, contentment of desires, working in a societal perspective, etc. (Ventegodt, 1995).

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Significance of the Study

The purpose of the current research was to study the association between symptoms severity, social support and quality of life among clients with major depressive disorder. The present study led to support mental health professionals and social workers to understand how much symptoms severity and social support show a significant influence on the quality of life of depressed patients. The current study creates an awareness that how mental health professionals manage individuals with emotional and stressful problems. The main purpose of the present research is to provide insight and create awareness that how policy makers, social worker and mental health professionals increase social support and enhance quality of life among patients with major depressive disorder.

2. Method

2.1 Research Design

Correlational research design was used in present study.

2.2 Sample and Sampling Strategy

Purposive sampling technique was utilized to recruit sample of 100 depressed adults.

2.3 Procedure

Firstly, researcher get institutional ethical clearance letter from University. Permission was taken from the authors of scales. Researcher prepare the booklet consisting on the informed consent hold demographic sheet and scales, provided to the participants and collect data then pilot study and main study was conducted.

2.4 Measures

2.4.1 Hamilton Depression Rating Scale (Hamilton, 1960; HAMD-17)

The HDRS (also known as the Ham-D) is the most widely used clinician-administered depression assessment scale. The original version contains 17 items (HDRS17) pertaining to symptoms of depression experienced over the past week. Hamilton Depression Rating Scale was originally developed by Hamilton, (1960). A later 21-item version (HDRS21) included 4 items intended to subtype the depression, but which are sometimes, incorrectly, used to rate severity. This tool has been interpreted in Urdu by Hashmi (2016). This scale has total 17 items. 4-point Likert scale (0= Absent to 4= Incapacitating) was used in this tool. The Cronbach alpha reliability of this scale was (α=.72).

2.4.2 Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, 1988)

The Multidimensional Scale of Perceived Social Support (MSPSS) was developed by Zimet (1988). This scale was translated by Jabeen (2013). This scale comprised three subscales: (a) Family, (b) Friends and (c) Significant Other. This instrument has 12 items. This scale used 7-point likert scale (1= very strongly disagree, 7= very strongly agree). The chronbach alpha of this tool is .91. The reliability of Multidimensional Scale of Perceived Social Support Scale found in the present study was (α=.93).

2.4.3 World Health Organization-Quality of Life Scale (WHOQOL; Vahedi, 2010)

World Health Organization-Quality of Life Scale was developed (Vahedi, 2010). This scale has 26 items. This scale comprised of four subscales (a) Physical domain, (b) Psychological domain, (c) Social relationship domain, (d) Environmental domain. This scale was measured on 5-point Likert scale (1= very dissatisfied, 5= very satisfied). The chronbach alpha reliability is .96. The reliability of World Health Organization-Quality of Life Scale found in the present study was (α=.93).

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3. Results

Table 1
Pearson Product Moment Correlation Analysis between Study Variables among Depressed and Non-Depressed Adults (n=100)

	Variables	1	2	3
1.	Symptoms Severity	-	0.04	-.30**
2.	Social Support	-	-	-0.15
3.	Quality of Life	-	-	-

** $P < 0.01$,*$P < 0.05$

Results revealed that symptoms severity has highly significant (p <.05) negative association with quality of life.

Table 2
Hierarchal Regression Analysis Used to Predicting Quality of Life (n=100)

	Quality of Life	
		Major Depressive Disorder
Predictors	**ΔR^2**	***β***
Step 1	.08**	
Symptoms Severity		-.30**
Step 2	.09	
Social Support		.29
Total R^2	11%	

Note: *p < .05. ,**p < .01. , ***p < .001.
a. Dependent Variable: Quality of Life
b. Predictors in the Models: Symptoms Severity, Social Support.

Results revealed that symptom severity was significant predictor of quality of life (p < .05).

Table 3
Independent Sample t-test between Gender Patients and Social Support (n=100)

Gender	t	df	*P*	Confidence Internal	
				LL	***UL***
Social Support	-.19	98	.05	4.95	.12

Note: t= Statistical Difference, df= Degree of Freedom, p= Significance Value, LL= Lower Limit, UL= Upper Limit.

An equal variances t test reveals a statistical reliable difference between the mean of gender for male's social support (M=27.52, s=5.89) and female's social support (M=30.00, s=6.57), t (-.19) =1.31, *p*=.05, α=.05.

4. Discussion

Findings of the current research revealed significant negative relationship between symptoms severity and quality of life. Prior investigates proved the results. A study was conducted to check the awareness, information, attitudes and practice of psychological illnesses, estimation the occurrence of and risk aspects for symptoms severity and examine relationship of symptoms severity of psychological distress with quality of life. Findings showed that awareness, information, attitudes and experience of symptoms severity showed negative relationship with quality of life. However, findings showed symptoms severity of psychological distress significantly negatively corelated with quality of life (Uddin, Bhar, Mahmud & Islam, 2017).

Another research was directed to observe the association of forerunner aspects, symptoms severity and quality of life of clients. Outcomes showed comprising entirely the factors clarified

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68% of the change in QOL. General, four factors reported for the usual overall change: worry, hopelessness, self-efficacy, and symptom severity. Results showed the antecedent aspects of symptom severity had a substantial incidental influence on QOL via the mediating factors. Findings also revealed symptoms severity has negative relationship with quality of life (Omran & Mcmillan, 2018).

Outcomes of the current research revealed not significant association between social support and quality of life. Prior researches reinforced the results. Alsubaie, Stain, Webster and Wardman, (2018) conducted a research to examined the association between social support and quality of life of students. Findings showed quality of life has not significant relationship with social support from family and peers. Another study was conducted to define the quality of life among caretakers of clients with serious psychological disease and observe the effect of social support, family pressure, and hopelessness on quality of life, and discover the mediating impact of sadness on the relationship between social support, family drain and QoL. Findings showed depression has negative relation with quality of life, social support was not significantly linked with family drain and quality of life (Jeyagurunathan et al., 2017).

Results of the current study revealed that females with major depressive disorder have higher level of social support as compare to males with major depressive disorder. Another study was conducted to explore the relationship between perceived social support and depression in a sample of emerging adults, and subsequently to identify the type of social support young people consider most helpful in dealing with this type of emotional distress. Findings showed that the score of social support was higher in females as compare to males (Hernáez et al., 2016).

Furthermore, Findings of the present study revealed symptoms severity was the significant predictor of quality of life. A study was conducted to examine the examined the effect of this procedure on psychiatric signs and quality of life in students. University undergraduates above 18 years without psychosis sign, profound depression episodes, or severe psychological risk were comprised, undergoing a psychiatric interview and assessment which comprised scientific evasion, quality of life, self-respect, compassion, and nervousness indication tools. Results showed symptoms severity and depressive signs were significant predictors of quality of life (Bermudez et al., 2020). In addition, Aburuz, (2018) conducted a research to observe the effect of nervousness and depression on quality of life among clients. Results revealed patients described poor quality of life in both physiological factor summary and psychological element summary. Findings showed nervousness and depression were important variances and predictors of quality of life.

Moreover, a research was conducted to examined the effect of symptoms severity on quality of life in students. Results showed symptoms severity was significant effected quality of life of many students specially who met the criteria for anxiety diseases. There were also important developments in depressive signs and quality of life (Bermudez et al., 2020). Another study was conducted to observe the effect of nervousness and depression on quality of life among patients. Results revealed patients described poor quality of life in both physiological factor summary and psychological element summary. Findings showed nervousness and depression were important variances of quality of life (Bahall, Legall& Khan, 2020).

4.1 Limitations and Recommendations

The sample size of present research was 100. And the sample of present study was short for better understanding. A larger sample size would allow researchers to have more data to analyze which would provide a better understanding of the topic. It will also enhance the validity and reliability of research. When a study is conducted with a small sample size there is more margin of error which decreases the validity.

4.2 Conclusions

It is evident from the current research and previous researches that patients with major depressive disorder who have high level of social support leaded towards better quality of life.

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Acknowledgement
Working on my MS Thesis has been both a wonderful and overwhelming experience. I am grateful to so many good people for ensuring the time I have spent working on this project has been an unforgettable experience. First of all, I would like to thank my family for the exceptional support, care and encouragement they have given me during these past months. Without their guidance and constant feedback, this project would not have been achievable. I gratefully acknowledge the support I received from the Riphah International University, Lahore, Pakistan that has ensured the completion of this project. I am thankful to the Participants who by agreeing to participate in this research and made this project possible.

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Article received 2022-02-09